MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08319

08309

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
LENGTH OF STAY (in this place): 1 mo 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 13, 3701-4
STREET ADDRESS (If rural give location): 2023 Sinclair Lane

3. NAME OF DECEASED: (First) CHARLES (Middle) (Last) BAKER
4. DATE OF DEATH: (Month) 9 (Day) 4 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	11-13-83	70 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk -
10B. KIND OF BUSINESS OR INDUSTRY: Unk -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Baker
14. MOTHER'S MAIDEN NAME: Mary Wahl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Bronchopneumonia	3 days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO arteriosclerotic cardio-vascular disease	1 year +
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	CBS associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.	one year +

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-23, 1954, to 9-4, 1954, that I last saw the deceased alive on 9-4, 1954, and that death occurred at 4:30 P M, from the causes and on the date stated above.

SIGNATURE: Walter K. Tonnesfeldt M.D. M.D.
ADDRESS: Springfield State Hospital
DATE SIGNED: 9/4/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-8-54	Holy Redeemer	Balto. Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 5, 1954	C. Harry Tikes	H. Sanders Son.	Matt & Broadway.

RECEIVED
SEP 8 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08320

08310

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 28 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) M. (Middle) Virginia (Last) Beyer M.D.
4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 1954

5. SEX: F. 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single 8. DATE OF BIRTH: Oct. 27 1890 9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician 10B. KIND OF BUSINESS OR INDUSTRY: Medicine 11. BIRTHPLACE (State or foreign country): Penna. 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wm H. Beyer 14. MOTHER'S MAIDEN NAME: Margaret Ann Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO. None 17. INFORMANT & ADDRESS: Mr. Maggie Dye - Finksburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

175 X

IMMEDIATE CAUSE (A) Carcinomatosis — about 6 mos

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Primary adeno carcinoma of ovary — about 2 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940, 19..., to 2 Sept, 1954, that I last saw the deceased alive on 2 Sept, 1954, and that death occurred at 4:20 AM, from the causes and on the date stated above.

SIGNATURE C. H. Laurent M. D. ADDRESS Sykesville, Md. DATE SIGNED 9-2-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 9-5-54 NAME OF CEMETERY OR CREMATORY Circle Hill LOCATION (City, town, or county) (State) Finksburg, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 4, 1954 REGISTRAR'S SIGNATURE C. Harry Weer 24. FUNERAL DIRECTOR ADDRESS Wm. Haight - Sykesville, Md.

RECEIVED
SEP 9 1954
BUREAU V. S.

08305

08321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 56

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster; LENGTH OF STAY (in this place) 45 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 84 W. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster; STREET ADDRESS (If rural, give location) 84 W. Green St.

3. NAME OF DECEASED (Type or Print): (First) Ada (Middle) Catherine (Last) Brown

4. DATE OF DEATH: (Month) Sept. (Day) 23 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 15, 1873

9. AGE last birthday: 80 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frederick County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Malachi Etzler

14. MOTHER'S MAIDEN NAME: Merian Mealy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT AND ADDRESS: Mrs. S. A. Wagaman Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Cerebral softening — Interval between onset and death: 4 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio Sclerosis — ?

(c) arteriosclerotic heart disease — ?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Flu bronchitis about Sept 1st to 4th

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1954, to Sept 23, 1954, that I last saw the deceased alive on Sept 22, 1954, and that death occurred at 2:15 P m., from the causes and on the date stated above.

SIGNATURE: Reese Kirkpatrick (Degree or title) M.D. ADDRESS Westminster Md DATE SIGNED 9/24/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Sept. 26, 1954

NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery

LOCATION (City, town, or county) (State): nr New Windsor, Md.

DATE REC'D BY LOCAL REG. 9-24-54

REGISTRAR'S SIGNATURE: Hiram Miller

24. FUNERAL DIRECTOR: John R. Byers ADDRESS: Westminster, Md.

RECEIVED
SEP 27 1954
BUREAU V. S.

08322

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08311

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 9, File 171 10-6-54 ot

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 38 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown, Maryland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Alice (Middle) M. (Last) Buffington

4. DATE OF DEATH: (Month) Sept. (Day) 29 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 2-3-1868

9. AGE last birthday 86 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Taneytown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Buffington

14. MOTHER'S MAIDEN NAME: Catherine Droneberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X

IMMEDIATE CAUSE (A) Cardiovascular Renal Disease — Interval between onset and death: Years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Diabetes — Years

DUE TO (C) Schizophrenia, paranoid type, plus mental deficiency — 38 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-8, 1952, to 9-29, 1954, that I last saw the deceased alive on 9-28, 1954, and that death occurred at 4:05 A M, from the causes and on the date stated above.

SIGNATURE Gabriel Sourcepeks, M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED 9/29/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Oct 1 1954 — NAME OF CEMETERY OR CREMATORY Reform Cemetery — LOCATION (City, town, or county) Taneytown (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept. 29, 1954 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR C. O. Fuss & Son — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10

RECEIVED
OCT 1 1954
BUREAU V. S.

08312 08323

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 82-83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airy, Maryland
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt. Airy, Maryland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) N. (Last) Cooksey
4. DATE OF DEATH (Month) September (Day) 6, (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept. 16, 1876	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
retired Fireman	B&O Railroad	Frederick Co., Maryland	USA

13. FATHER'S NAME: Pinkney Cooksey
14. MOTHER'S MAIDEN NAME: Kate Rehart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No.	None	Mrs. Fannie Cooksey Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Hypertension Coronary Disease — years.
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J Thacker M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9/6/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-9-54	Pine Grove Cemetery	Mt. Airy, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 8-54	Robert R. Haurit	C. M. Weltz	Winfield, Maryland

RECEIVED
SEP 14 1954
BUREAU V. S.

08313

08324
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital Sykesville, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Baltimore
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN ~~Catonsville~~ Baltimore
STREET ADDRESS (If rural, give location) 138 N. Kenwood Ave.

3. NAME OF DECEASED: (First) EDGAR (Middle) W. (Last) DAWES
4. DATE OF DEATH (Month) Sept (Day) 4 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Single	Aug. 15, 1921	33 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore Md.	U.S.

13. FATHER'S NAME: Edgar Dawes
14. MOTHER'S MAIDEN NAME: Theresa Isnhoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no none	none	Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocardial infarction	several days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Coronary arteriosclerosis	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Epilepsy, idopathic — 33yrs.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Lewis J. Unruh M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9/4/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 8 1954	Baltimore Cemetery	Baltimore, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/7/54	C W Hedrick JCS	John A. Moran,	3000 E. Balto. St.

MARYLAND 08314

08325

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll County; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (in this place) since 5-25-32; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mabel (Middle) Bunting (Last) Earp

4. DATE OF DEATH: (Month) Spt (Day) 13 (Year) 1954

5. SEX: fem.

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Div.

8. DATE OF BIRTH: April 5, 1872

9. AGE last birthday: 82 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): stenographer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph O. Bunting

14. MOTHER'S MAIDEN NAME: Sarah E. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ---; (If year, give war or dates of service): ---

16. SOCIAL SECURITY No.: ---

17. INFORMANT AND ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	1 wk
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) hypertensive cardiovascular disease,	more than 20 yrs
	(c) arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: psychosis with somatic disease

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): ---

TIME OF INJURY (Month) (Day) (Year) (Hour): ---; INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from May 25, 1932, to Spt. 13, 1954, that I last saw the deceased alive on Spt. 13, 1954, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gerhard Sonnenfeld M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED Spt. 13, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE 9/15/54; NAME OF CEMETERY OR CREMATORY Woodlawn Cem.; LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REG. 9-15-54; REGISTRAR'S SIGNATURE Lois Kerbaugh Deputy

24. FUNERAL DIRECTOR Wm. J. Pickmer & Sons; ADDRESS Ellicott City, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08326

08315

CERTIFICATE OF DEATH

Reg. Dist. No. 3 b

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster Rural
LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural give location) Broadway

3. NAME OF DECEASED: (Type or Print) (First) CARRIE (Middle) ISABELLE (Last) ECKER

4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: July 28 1879

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram F Ecker

14. MOTHER'S MAIDEN NAME: Anna Mitten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs John R Barnes Westminster, Md Rural

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lymphosarcoma - Pontid DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 1 year

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/10 ....., 1954 ., to 9/8 ., 1954, that I last saw the deceased alive on 9/6 ....., 1954, and that death occurred at 2 AM ., from the causes and on the date stated above.

SIGNATURE James T Nixon (Degree or title) M.D. ADDRESS Westminster Md DATE SIGNED 9/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept 10-1954 NAME OF CEMETERY OR CREMATORY Evergreen LOCATION (City, town, or county) Finksville (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 9-9-54 REGISTRAR'S SIGNATURE Harriet Ohler

24. FUNERAL DIRECTOR D E Hartzler & Sons ADDRESS Union Bridge Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08316 — Reg. Dist. No. 08327

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rural

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor
STREET ADDRESS (If rural give location): Rural

3. NAME OF DECEASED (Type or Print): First: CARROLL — Middle: A. — Last: ECKER

4. DATE OF DEATH: (Month) Sept (Day) 4 (Year) 1954

5. SEX: male — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married — 8. DATE OF BIRTH: 2/26/1880 — 9. AGE last birthday: 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Nursery — 10b. KIND OF BUSINESS OR INDUSTRY: Orchard — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Fred Ecker — 14. MOTHER'S MAIDEN NAME: Sarah Fritz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service): no — 16. SOCIAL SECURITY NO.: 212-03-5385 — 17. INFORMANT & ADDRESS: Raymond Ecker, New Windsor, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Suffocation — 2 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Cardiac decompensation — 7 days
DUE TO
(c) Cardio Vascular Disease — ?0

+2.2.1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: X

19a. DATE OF OPERATION: X — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20, 1954, to 9-4, 1954, that I last saw the deceased alive on 9-4, 1954, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

SIGNATURE: N. L. Stone M.D. — (Degree or title) — ADDRESS: 121 E. Green St. Westminster — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/7/54 — NAME OF CEMETERY OR CREMATORY: Evergreen — LOCATION (City, town, or county) (State): Uniontown, Md.

DATE REC'D BY LOCAL REGISTRAR: 9-6-54 — REGISTRAR'S SIGNATURE: [illegible] — 24. FUNERAL DIRECTOR: D. D. Hafer & Sons — ADDRESS: New Windsor, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08328

08317

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster-Rural
LENGTH OF STAY (In this place) 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glover Convelescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Henry (Last) Erb

4. DATE OF DEATH: (Month) Sept. (Day) 21, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: August 14, 1870

9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: General work

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Erb

14. MOTHER'S MAIDEN NAME: Susanna R.E.Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-20-1787

17. INFORMANT & ADDRESS: Mrs. Wm. K. Flickinger, Union Bridge, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Arteriosclerotic Cerebrovascular Disease

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1954 to 9/21/54 19 , that I last saw the deceased alive on 9/21/54 19 , and that death occurred at 12 30 P M, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS DATE SIGNED 9/22/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept. 24, 1954

NAME OF CEMETERY OR CREMATORY Baust Cemetery

LOCATION (City, town, or county) (State) Tyrone, Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR 9-23-54

REGISTRAR'S SIGNATURE Hamil Mills

24. FUNERAL DIRECTOR ADDRESS C.O.Fuss & Son, Taneytown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08329

08318

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Taneytown
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) J. (Last) Eyler

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: December 28, 1857

9. AGE last birthday: 96 yrs.
IF UNDER 1 YEAR, Months Days
IF UNDER 24 HRS., Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Hess

14. MOTHER'S MAIDEN NAME: Elizabeth A. Correll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. Edgar Fink, Taneytown, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Senile Gangrene

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arterio Sclerosis DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1954, to Sept 2, 1954 that I last saw the deceased alive on 9-1-54, and that death occurred at 1 A M, from the causes and on the date stated above.

SIGNATURE T. N. Legg M. D. ADDRESS Union Bridge DATE SIGNED 9-3-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9/5/54

NAME OF CEMETERY OR CREMATORY Lutheran Cemetery

LOCATION (City, town, or county) (State) Harney, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept 3, 1954

REGISTRAR'S SIGNATURE Ethel M Mehring Local

24. FUNERAL DIRECTOR C.O.Fuss & Son ADDRESS Taneytown, Maryland

08319

08331

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (In this place) 2 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS (F.) #1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) R. F. D. #1

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) JANE (Last) FIEGEL

4. DATE OF DEATH (Month) (Day) (Year) Sept 17 1954

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH: Jan 7 1874 | 9. AGE last birthday: 80 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housework | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Hagerstown Md. | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jehu Amon | 14. MOTHER'S MAIDEN NAME: Lucy Amoss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: — — | 17. INFORMANT & ADDRESS: Mrs Katherine Wimpie Woodbine Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Hemorrhage, Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 16 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE W. M. J. Forrest M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/19/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/20/54	Moreland Mem. Pk.	Balto. Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/21/54	A. W. Hedrick	W. M. J. Forrest & Sons	Balto 17, Md.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 · 08331

08320

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 2 y, 2m, 2d
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-1
STREET ADDRESS (If rural give location) 702 West Fayette Street

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) FITZGERALD

4. DATE OF DEATH: (Month) 9 (Day) 20 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: unknown

9. AGE last birthday: 68? yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Myocardial infarction due to — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (S) DUE TO (B) myocardial insufficiency

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) arteriosclerotic cardiovascular disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic Brain syndrome associated with bromide intoxication, plus arteriosclerotic features — unknown

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/25, 1954, to 9/20/, 1954, that I last saw the deceased alive on 9/20, 1954, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

SIGNATURE Ray A Hayes M. D. ADDRESS Sykesville, Maryland DATE SIGNED 9/20/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Embalmed | DATE THEREOF Sept. 22 1954 | NAME OF CEMETERY OR CREMATORY U. J. Maryland Mt. Lo | LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 4, 1954 | REGISTRAR'S SIGNATURE C. Harry Heuer [illegible] | 24. FUNERAL DIRECTOR The Anthony Bond Co. Inc. | ADDRESS Maryland

VS. A15—10-

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08321

CERTIFICATE OF DEATH

08332

Reg. Dist. No. 77

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
STREET ADDRESS (If rural give location) Route # 1

3. NAME OF DECEASED: (Type or Print) (First) RALPH (Middle) LINDSAY (Last) FREEMAN

4. DATE OF DEATH: (Month) (Day) (Year) September 28 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: June 16, 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 Hrs.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Nova Scotia

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: David C. Freeman

14. MOTHER'S MAIDEN NAME: Antennette Fidito

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO none

17. INFORMANT & ADDRESS: Springfield State Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Arteriosclerotic Cardiovascular Disease — years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with circulatory disturbance. — About 1 month

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1954, to 9-28, 1954, that I last saw the deceased alive on 9-28, 1954, and that death occurred at 6:00 AM, from the causes and on the date stated above.

SIGNATURE Ray H. Hayes — ADDRESS M.D. Springfield State Hospital — DATE SIGNED 9/28/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Oct. 1, 1954 — NAME OF CEMETERY OR CREMATORY Carrollton Manor Cemetery — LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 29, 1954 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR J. Bankard & Son — ADDRESS Westminster, Md.

VS. A15 — 10 —

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08333

08322

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge — LENGTH OF STAY (in this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rural

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge
STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED: (First) MARY (Middle) MARTHA (Last) FRITZ

4. DATE OF DEATH: (Month) Sept (Day) 14 (Year) 1954

5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 11/12/1889 | 9. AGE last birthday: 64 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): housewife | 10b. KIND OF BUSINESS OR INDUSTRY: at home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Moses Horning

14. MOTHER'S MAIDEN NAME: Elizabeth Garwick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no | (If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-18-2486

17. INFORMANT & ADDRESS: Walter Fritz, Union Bridge, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Failure — Interval Between Onset And Death: 3 Weeks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rheumatic Cardio-Vascular Disease — Childhood.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July ..., 1930, to 9/14/54, 19.., that I last saw the deceased alive on 9/14/54, 19.., and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): M. E. Robertson M.D. — ADDRESS: New Windsor, Md — DATE SIGNED: 9/14/54

23. BURIAL, CREMATION, REMOVAL (Specify): Buried | DATE THEREOF: 9/16/54 | NAME OF CEMETERY OR CREMATORY: Pipe Creek Cem. | LOCATION (City, town, or county): Carroll County (State): Md

DATE REC'D BY LOCAL REGISTRAR: Sept. 14, 1954 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: D. D. Hahn & Sons — ADDRESS: Union Bridge, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RE
SEP 16
BUREAU V. S.

08334

MARYLAND 08323

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md
LENGTH OF STAY (in this place) 28 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md
STREET ADDRESS (If rural, give location) Church St.

3. NAME OF DECEASED (Type or Print): (First) ALBERT (Middle) OTIS (Last) GAMBER

4. DATE OF DEATH: (Month) 9 (Day) 29 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, (MARRIED) WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 30 July 1889

9. AGE last birthday: 65 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter

10b. KIND OF BUSINESS OR INDUSTRY: painter

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert F Gamber

14. MOTHER'S MAIDEN NAME: Ella Zentz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): (no)

16. SOCIAL SECURITY NO.: 0

17. INFORMANT AND ADDRESS: wife - Sykesville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac arrest — Interval between onset and death: 1 Hr

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Uremia, Anemia — 1953

(c) Carcinoma bladder

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Sept 1954

19b. MAJOR FINDINGS OF OPERATION: Carcinoma bladder

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): 0

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 0 (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): 0 m.

INJURY OCCURRED While at Work ☑ Not While At work ☐

HOW DID INJURY OCCUR? 0

22. I hereby certify that I attended the deceased from 22 Sept, 19 54, to 29 Sept 19 54, that I last saw the deceased alive on 29 Sept, 19 54, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Howard E Hall md — ADDRESS Sykesville, Maryland — DATE SIGNED 29 Sept 54

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 10-1-1954 — NAME OF CEMETERY OR CREMATORY: Providence — LOCATION (City, town, or county) (State): Carroll Co., Marvland

DATE REC'D BY LOCAL REG.: Sept. 30, 1954 — REGISTRAR'S SIGNATURE: C. Harry Uhler

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield, Maryland

RECEIVED
OCT 1
BUREAU V. S.

08334 MARYLAND STATE DEPARTMENT OF HEALTH 08335

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll Co; MARYLAND Md; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge; LENGTH OF STAY (in this place) —; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) Howard (Last) Garner

4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 19 54

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 12-18-1874

9. AGE last birthday: 79 yrs.; If under 1 year: Months 9, Days 24; If under 24 hrs.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Carroll Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Garner

14. MOTHER'S MAIDEN NAME: Amanda Myers Hanna Yon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): (No)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mr Carl Neuwander Union Bridge Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardio-Vascular Disease — Interval Between Onset and Death —

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): —

(COUNTY): —

(STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1949, to 9/6/54, 19....., that I last saw the deceased alive on 9/6/54, 19....., and that death occurred at 8 45 P. m., from the causes and on the date stated above.

SIGNATURE: M. E. Robertson (Degree or title) M.D. ADDRESS: New Windsor, Md. DATE SIGNED: 9/6/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Sept 9-54

NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

LOCATION (City, town, or county): Near Westminster

(State): Md.

DATE REC'D BY LOCAL REG.: Sept. 7, 1954

REGISTRAR'S SIGNATURE: Mabel Repp

24. FUNERAL DIRECTOR: Raymond T Wright ADDRESS: Union Bridge Md

RECEIVED
SEP 10 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08336

08306 CERTIFICATE OF DEATH Reg. Dist. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place): Most his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bond St. Lyt.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) Bond St., Lyt.

3. NAME OF DECEASED: (Type or Print) (First) DENTON (Middle) — (Last) GEHR

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 1 1880

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Brick Store

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Gehr, Sr.

14. MOTHER'S MAIDEN NAME: Alice Shriver

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 212-03-4021

17. INFORMANT & ADDRESS: George R. Gehr II. Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio sclerotic C-V disease DUE TO

(c)

Interval Between Onset And Death: (a) Minute. (b) 3 years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-13 ..., 1954, to 9-21 ..., 1954, that I last saw the deceased alive on 9-21 ..., 1954, and that death occurred at 9 P. ..., from the causes and on the date stated above.

SIGNATURE James D. Shard (Degree or title) M. D. ADDRESS Westminster Md DATE SIGNED 9/23/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept. 24. 54 NAME OF CEMETERY OR CREMATORY Westminster Cemetery LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-23-54 REGISTRAR'S SIGNATURE Harriet Fuller

24. FUNERAL DIRECTOR J. S. Myers Jr. ADDRESS Westminster Md.

SEP
IRLAU V. S.

09253

MARYLAND 08325

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (In this place): MARYLAND 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Howpital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
STREET ADDRESS (If rural, give location): Springfield State Hospital

3. NAME OF DECEASED (Type or Print): (First) Julia (Middle) Ann (Last) George

4. DATE OF DEATH: (Month) Spt (Day) 19 (Year) 1954

5. SEX: fem.

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 1876

9. AGE last birthday: 78 yrs. If under 1 year: Months. If under 24 hrs: Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas George

14. MOTHER'S MAIDEN NAME: Mary Hedley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ——

16. SOCIAL SECURITY NO.: ——

17. INFORMANT AND ADDRESS: records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) cerebro-vascular accident — Interval between onset and death: minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis with hypertension — more than 20 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: mental deficiency without psychosis — more than 50 yrs

19a. DATE OF OPERATION: ——

19b. MAJOR FINDINGS OF OPERATION: ——

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ——

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ——

(CITY OR TOWN): ——

(COUNTY): ——

(STATE): ——

TIME OF INJURY (Month) (Day) (Year) (Hour): —— m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from 11-30 ....., 19.03., to 9-19 ....., 1954 ., that I last saw the deceased alive on 9-19 ....., 19.54 , and that death occurred at 5:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Martin Gross, M.D.

ADDRESS: Sykesville, Md.

DATE SIGNED: 9-19-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 10-18-54

NAME OF CEMETERY OR CREMATORY: Springfield Hospital

LOCATION (City, town, or county) (State): Sykesville, Md.

DATE REC'D BY LOCAL REG.: Oct. 18, 1954

REGISTRAR'S SIGNATURE: C. Harris Eiler

24. FUNERAL DIRECTOR: Edward Haight - Sykesville, Md.

ADDRESS: Edward H. Haight

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08337

08307

CERTIFICATE OF DEATH

Reg. Dist. No. 56

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-54

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 197 Penna. Avenue

3. NAME OF DECEASED: (Type or Print) (First) Wilbur (Middle) Dewey (Last) Gorsuch

4. DATE OF DEATH: (Month) Sept. (Day) 21, (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 5, 1898

9. AGE last birthday: 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Engeneering Firm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Gorsuch

14. MOTHER'S MAIDEN NAME: Ida Lambert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-01-4939

17. INFORMANT & ADDRESS: Mrs. Myrtle Gorsuch, Westminster, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Dilatation	hrs
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Acute Broncho Pneumonia	3 days
DUE TO		
	(c) Bronchitis	2 Wks

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic Myocarditis — 3 Yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-20, 1954 to 9-21, 1954 that I last saw the deceased alive on 9-21, 1954 and that death occurred at 3.30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Chas. R. Forty M.D. Westminster Md 9-21-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept. 24, 1954 — NAME OF CEMETERY OR CREMATORY: Kriders Cemetery — LOCATION (City, town, or county) (State): Westminster, Maryland

DATE REC'D BY LOCAL REG. 9-23-54 — REGISTRAR'S SIGNATURE: Harriet Miller

24. FUNERAL DIRECTOR ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

...UREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08338

08326 # CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll Co. MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 7 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pleasant Valley

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural give location) Pleasant Valley

3. NAME OF DECEASED: (Type or Print) (First) RAYMOND (Middle) LLOYD (Last) HAHN

4. DATE OF DEATH: (Month) Sept. (Day) 25 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	March 26 1892	62 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Cost Accountant	Cent. Am, Co.	Pleasant Valley Carroll Co. Md.	U.S.A.

13. FATHER'S NAME: Edwin M. Hahn

14. MOTHER'S MAIDEN NAME: Laura Belle Devilbiss

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 067-07-2545

17. INFORMANT & ADDRESS: Mrs. Hal R. Hahn. Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Arteriosclerotic Cardiovascular Renal Disease — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

Interval Between Onset And Death: year

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — **INJURY OCCURED** While at Work ☐ Not While At Work ☐ — **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from ..... 1952, to Sept 25, 1954, that I last saw the deceased alive on Sept 24, 1954, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE James T. Shaum (Degree or title) M.D. ADDRESS Westminster Md DATE SIGNED 9/27/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept. 28. 54	Pleasant Valley Cem.	Rural, Westminster	Md.

DATE REC'D BY LOCAL REGISTRAR 9-27-54 — REGISTRAR'S SIGNATURE Hamil Smith

24. FUNERAL DIRECTOR J. E. Myers Jr. — ADDRESS Westminster Md.

SEP
LOWLAND V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08339

03327 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 4Y 7M 15 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 402 Columbia Street

3. NAME OF DECEASED: (Type or Print) (First) HARRIET (Hattie) (Middle) (Last) HICE

4. DATE OF DEATH: (Month) 9 (Day) 14 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W

8. DATE OF BIRTH. 3/18/79

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chambermaid

10B. KIND OF BUSINESS OR INDUSTRY: hotels

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Holtman

14. MOTHER'S MAIDEN NAME: Sarah Burley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) DUE TO: Thrombosis of superior mesenteric artery — 3 days

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO: marked arteriosclerotic vascular disease — years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome assoc. with cerebral arteriosclerosis — 4 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/12, 19 54 to 9/14, 19 54, that I last saw the deceased alive on 9/14, 19 54, and that death occurred at 6:50 A.M. from the causes and on the date stated above.

SIGNATURE Roy H. Hayes M. D. ADDRESS Sykesville, Maryland DATE SIGNED 9/14/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Sept. 16, 1954 | NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery | LOCATION (City, town, or county) (State) Carroll Co. Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 15, 1954 | REGISTRAR'S SIGNATURE A. Harry Weir

24. FUNERAL DIRECTOR C. M. Walt ADDRESS Winfield, Md.

VS. A15 — 10 -

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

SEP 20 19[illegible]
BUREAU V. E

VS. A15—10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08340

08323

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Sykesville R.D.
STREET ADDRESS (If rural give location) Sykesville

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Elizabeth (Last) Hafer

4. DATE OF DEATH (Month) 4 (Day) 29 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: 3-20-1883

9. AGE last birthday 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Shaw

14. MOTHER'S MAIDEN NAME: Sarah Kimmel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. Mary Hafer Sykesville

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE (A) Hypertensive cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH 10 yrs -

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF any, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) with chr. myocarditis — 10 yrs -
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1954, 19 , to 29 Sept, 1954, that I last saw the deceased alive on 29 Sept, 1954, and that death occurred at 1:15 P.M., from the causes and on the date stated above.
SIGNATURE M.D. Dr. Lawson
ADDRESS Liberty Rd. Sykesville R.D.
DATE SIGNED 9/29/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-2-54
NAME OF CEMETERY OR CREMATORY St. Mary's
LOCATION (City, town, or county) (State) Ellicott City, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 30, 1954
REGISTRAR'S SIGNATURE E. [illegible]
24. FUNERAL DIRECTOR [illegible]
ADDRESS [illegible]

OCT 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08341

08329 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 1105 Belvedere Avenue

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) PATTERSON (Last) HOPKINS

4. DATE OF DEATH: (Month) 9 (Day) 21 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May-25-1873

9. AGE last birthday 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Composer and Organist

10B. KIND OF BUSINESS OR INDUSTRY: Music

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Johns Scott Hopkins

14. MOTHER'S MAIDEN NAME: Mary Alice Lampher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Hospital records & Lucy Wigley Hopkins (Wife)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Myocardial infarction — hours

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerotic cardiovascular disease — years
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with brain disease, psychotic reaction — years

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-16 ..., 1954, to 9/21 ., 1954, that I last saw the deceased alive on 9/21, 1954, and that death occurred at 1:10 AM DST, from the causes and on the date stated above.

SIGNATURE Ray H. Hayes M. D. ADDRESS Sykesville, Maryland DATE SIGNED 9/21/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Sept 23/54 | NAME OF CEMETERY OR CREMATORY Dorsey | LOCATION (City, town, or county) Woodlawn Md (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 21, 1954 | REGISTRAR'S SIGNATURE C. Harry Zeller | 24. FUNERAL DIRECTOR Stewart Mortuary | ADDRESS Balto. Md.

VS. A15 — 10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08308

CERTIFICATE OF DEATH

08342

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westminster
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 Penna. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 110 Penna. Ave.

3. NAME OF DECEASED: (First) LOLA (Middle) AMANDA (Last) HOUCK
4. DATE OF DEATH: (Month) Sept. (Day) 13 (Year) 1954

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: April 15, 1889
9. AGE last birthday: 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Hand-stitcher
10b. KIND OF BUSINESS OR INDUSTRY: Clothing factory
11. BIRTHPLACE (State or foreign country): Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Lester
14. MOTHER'S MAIDEN NAME: Susan Reinman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 213-05-3848
17. INFORMANT & ADDRESS: Nevitt B. Houck, Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Pancreas — Interval Between Onset And Death: 3 mos

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Carcinoma of left breast. — 18 mos
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 19 54
19b. MAJOR FINDINGS OF OPERATION: Carcinoma-head of Pancreas
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/19, 19 54, to 9/13, 19 54, that I last saw the deceased alive on 9/13, 19 54, and that death occurred at 11 Pm, from the causes and on the date stated above.
SIGNATURE (Degree or title) Kirstie Barr M.D.
ADDRESS Westminster Md.
DATE SIGNED 9/14/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept 17 54
NAME OF CEMETERY OR CREMATORY Riders Cemetery
LOCATION (City, town, or county) Rural, Westminster (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-14-54
REGISTRAR'S SIGNATURE Hazel Miller
24. FUNERAL DIRECTOR J. E. Myers Jr.
ADDRESS Westminster Md.

954

Item 9: File G 169 - 9-14-54 L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08343

08330 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

M

I

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

1. PLACE OF DEATH:
COUNTY: CARROLL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
LENGTH OF STAY (in this place): 6 mos. 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural give location): 4339 Glenmore Avenue

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) CARL EMANUEL (Last) KAISS

4. DATE OF DEATH: (Month) 9 (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: March 8- 1876

9. AGE last birthday: 78 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Steward

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August Kaiss

14. MOTHER'S MAIDEN NAME: Caroline Letmate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardiovascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 8 years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Terminal Bronchopneumonia — 2 days

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome with cerebral arterio-sclerosis with psychotic reaction — 8 years

19A. DATE OF OPERATION: **19B. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **21B. PLACE** (Home, farm, factory, OF INJURY street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. **21E. INJURY OCCURRED** While at work ☐ Not while at work ☐ **21F. HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from 2/16, 1954, to 9/8/54, 1954, that I last saw the deceased alive on 9/8/, 1954, and that death occurred at 2:10 P.M. DST, from the causes and on the date stated above.

SIGNATURE Walter H. Fornwalt M. D. ADDRESS Sykesville, Maryland DATE SIGNED 9/8/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Sept 11-1954 — NAME OF CEMETERY OR CREMATORY: Parkwood Cem — LOCATION (City, town, or county): Balto (State): Md

DATE REC'D BY LOCAL REGISTRAR: 9-9-54 — REGISTRAR'S SIGNATURE: C. W. Hedrick

24. FUNERAL DIRECTOR ADDRESS: Lassahn Funeral Home 7701 Belair Rd

08331 08344

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) since 12/22/49
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 39 West Street

3. NAME OF DECEASED: (Type or Print) (First) Luka (Middle) Nicolai (Last) KOLIDA

4. DATE OF DEATH (Month) (Day) (Year) September 14 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH: Dec. 15, 1894

9. AGE Last birthday: 59 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farm work

10b. KIND OF BUSINESS OR INDUSTRY: ---York-

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: Nicholai Kolada

14. MOTHER'S MAIDEN NAME: Alexandia ---York-

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Old and fresh myocardial infarction due to coronary	about 2 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) arteriosclerosis	instantaneous
	DUE TO (c) ---	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with mental deficiency — more than 5 yrs.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDING OF OPERATION: ---

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY ---

21c. (City or town) (County) (State) ---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21e. INJURY OCCURRED While at work ☐ Not while at work ☐ ---

21f. HOW DID INJURY OCCUR? ---

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE David I Ehrenfeld M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/14/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-16-54	Springfield	Sykesville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 16, 1954	C. Harvey Klee	Luther M. Haight	Hyattsville, Md.

SEP 20 1954

08332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08345 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Taneytown
LENGTH OF STAY (in this place): 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Rural Taneytown
STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED: (Type or Print) (First) LESTER (Middle) Samuel (Last) Koons

4. DATE OF DEATH (Month) Sept (Day) 23 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 4, 1903

9. AGE last birthday: 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Koons

14. MOTHER'S MAIDEN NAME: Jennie Gilbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 220-16-1110

17. INFORMANT & ADDRESS: Mrs. Lester Koons, Taneytown, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Compound Fracture of Skull — —

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: **19b. MAJOR FINDING OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY: Auto

21c. (City or town) Taneytown (County) Carroll (State) Md

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 23-54 2p M.

21e. INJURY OCCURRED While at work ☑ Not while at work ☐

21f. HOW DID INJURY OCCUR? Automobile accident

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Moran M. D.

CHIEF MEDICAL EXAMINER ☐ / DEPUTY MEDICAL EXAMINER ☑ / ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED 9/23/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Sept. 27, '54

NAME OF CEMETERY OR CREMATORY: Baust Cemetery

LOCATION (City, town, or county) (State): Tyrone, Carroll CO., Maryland

DATE REC'D BY LOCAL REG.: Sept. 24, 1954

REGISTRAR'S SIGNATURE: Ethel M Mehring Local

24. FUNERAL DIRECTOR ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

08333

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08346

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Greenmount
LENGTH OF STAY (In this place) 6 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Greenmount Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Arthur (Middle) Grant (Last) Leasher.

4. DATE OF DEATH: (Month) Sept (Day) 23 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: October 6, 1877

9. AGE last birthday: 76 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Road Superviser

10b. KIND OF BUSINESS OR INDUSTRY: County Roads

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: David Leisher

14. MOTHER'S MAIDEN NAME: Emma Clapper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-32-2565

17. INFORMANT AND ADDRESS: Irma M. Clark, Greenmount Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis Cardio Vascular Lesion

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1952, to Sept 23, 1954, that I last saw the deceased alive on Sept 20, 1954, and that death occurred at 11:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph E. Rush MD Hampstead Md Sept 23, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEN: 9-25-54

NAME OF CEMETERY OR CREMATORY: Fairview

LOCATION (City, town, or county) (State): Carroll Co Md

DATE REC'D BY LOCAL REG. 9/23/54

REGISTRAR'S SIGNATURE: Henry Lees

24. FUNERAL DIRECTOR: Edw A Wilson, Hampstead Md ADDRESS

BUREAU V. S.

08334

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08347 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) since 10/23/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 19 Valley St

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CHARLES	HENRY	LYONS	Sept	21	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	White	married	6-10-79	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
dish-washer	Hotel	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Lyons	Frances Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	None	Record of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Manic - depressive psychosis depressed type — about 20 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
—	—	

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
—	—	—

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
— M.	—	—

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 9/21/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-24-54	St Michaels	Frostburg, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 22, 1954	C. Stacy Wise	J. J. Hunt & Son	Frostburg, Md

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08335

MARYLAND STATE DEPARTMENT OF HEALTH

08348

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Avondale
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 255 E. Main

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) LESTER (Last) MAGIN
4. DATE OF DEATH: (Month) 9 (Day) 25 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 17, 1886
9. AGE last birthday: 67 yrs.
If under 1 year: Months / Days / If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bakes Ret. Employee
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Magin
14. MOTHER'S MAIDEN NAME: Minnie Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY No.: 217-18-8743
17. INFORMANT AND ADDRESS: Ada V. Magin 255 E. Main Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Coronary Thrombosis (?) — Unknown

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Body found in Field about 12 hrs after death.
(c) Was Dairy Farmer Operation Worked up Hill to Barn

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Avondale (CITY OR TOWN) Carroll (COUNTY) Maryland (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Reuben Bare (Degree or title) M.D. ADDRESS: Westminster Maryland DATE SIGNED: 9/26/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 27, 1954
NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
LOCATION (City, town, or county): Westminster (State): Md.

DATE REC'D BY LOCAL REG.: 9-27-54
REGISTRAR'S SIGNATURE: Hazel Fisher
24. FUNERAL DIRECTOR: Harman Funeral Home ADDRESS: Westminster Md.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08349

08336

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Springfield State Hospital
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 6 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thermont
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Joseph Grover Cleveland Marshall

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 19, 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10/4/83

9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Rented Farms

11. BIRTHPLACE (State or foreign country): Marland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Marshall

14. MOTHER'S MAIDEN NAME: Caraline Seacrist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-30-9031

17. INFORMANT & ADDRESS Mrs. Myrtle Marshall Thermont, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42241

IMMEDIATE CAUSE (A) Arteriosclerotic Cardiovascular disease

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: Years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with Disturbance of Metqoblism, growth or nutrition ~~with senile brain Disease, with Psychotic reaction~~ 9 months

19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3/54, 19.., to 9/19/54, 19...., that I last saw the deceased alive on 9/19/54, 19.., and that death occurred at 8:15, AM, from the causes and on the date stated above.

SIGNATURE Ray A Mayer M. D. ADDRESS Sykesville, Md. DATE SIGNED 9-19-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept.22.1954

NAME OF CEMETERY OR CREMATORY United Brethern Cem.

LOCATION (City, town, or county) (State) Thurmont.Fredk Co. MD

DATE REC'D BY LOCAL REGISTRAR Sept. 20, 1954

REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR M.L.Creager & Son. ADDRESS Thurmont MD.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08350

08337

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 2 mos, 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick
STREET ADDRESS (If rural give location) 221 Seventh Street

3. NAME OF DECEASED: (Type or Print) (First) IDA (Middle) VIRGINIA (Last) MYERS

4. DATE OF DEATH: (Month) 9 (Day) 19 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 6/20/73

9. AGE last birthday 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Zimmerman

14. MOTHER'S MAIDEN NAME: Mary Renn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardiovascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome, senile brain disease since 5/54

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/7, 19 54 to 9/19, 1954, that I last saw the deceased alive on 9/19, 19 54, and that death occurred at 11 P M, from the causes and on the date stated above.

SIGNATURE Walter R. Sonnenfeld M. D. ADDRESS Sykesville, Maryland DATE SIGNED 9/20/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 23 Sept 1954

NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery

LOCATION (City, town, or county) (State) Frederick, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 21, 1954

REGISTRAR'S SIGNATURE C. Harry Derr

24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland

SEP
ARMY U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08351

08333 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 3yrs. 1½mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Prince George's
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bettsville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MILDRED (Middle) (Last) PARKER

4. DATE OF DEATH: (Month) (Day) (Year) September 25 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: June 19, 1877

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alva Parker

14. MOTHER'S MAIDEN NAME: Louise Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk-

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 17 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Hypertensive cardio-vascular disease — years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Epileptic psychosis — 37 years+

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1, 1950 to 9-25, 1954, that I last saw the deceased alive on Sept. 25, 1954, and that death occurred at 8:20 A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnendeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 9/25/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9-28-54

NAME OF CEMETERY OR CREMATORY Bettsville

LOCATION (City, town, or county) (State) Bettsville Md

DATE REC'D BY LOCAL REGISTRAR Sept. 26, 1954

REGISTRAR'S SIGNATURE C. Harry Uber

24. FUNERAL DIRECTOR Dorsett Henderson ADDRESS Laurel, Md.

SEP 23 1937
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08352

08339

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 1Y 3M, 27 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 635 Bartlett Avenue, Balto.18

3. NAME OF DECEASED: (Type or Print) (First) FRANCES (Middle) MARY (Last) RATTIGAN

4. DATE OF DEATH. (Month) 9 (Day) 10 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 4/23/67

9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk -

10B. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): USA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk -

14. MOTHER'S MAIDEN NAME: Unk -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE H 22.1

(A) Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) arteriosclerosis — years

DUE TO (C) Gangrene of both feet — days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain dysdrome associated with senile brain disease — about 4 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/30, 1954 to 9/10., 1954 that I last saw the deceased alive on 9/10., 1954, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

SIGNATURE Werner H. Sonnendecker M.D. M.D. — ADDRESS Sykesville, Maryland — DATE SIGNED 9/10/54

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial — DATE THEREOF 9-18-54 — NAME OF CEMETERY OR CREMATORY Springfield Hosp. — LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 18, 1954 — REGISTRAR'S SIGNATURE C. Henry Edens

24. FUNERAL DIRECTOR Luther H. Haight — ADDRESS Sykesville, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08353

08340 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10/53

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prof. Raymond
LENGTH OF STAY (in this place) 65 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prof. [illegible]
STREET ADDRESS (If rural give location) [illegible]

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) W. (Last) Fowler

4. DATE OF DEATH (Month) Aug. (Day) 1 (Year) 1954

5. SEX M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower | 8. DATE OF BIRTH June 24 1870 | 9. AGE last birthday 78 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10B. KIND OF BUSINESS OR INDUSTRY: Farm | 11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible] H. Fowler | 14. MOTHER'S MAIDEN NAME: Emma D. Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. Unk. | 17. INFORMANT & ADDRESS. Mrs. [illegible] Taneytown Rt. 2 Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

240

IMMEDIATE CAUSE (A) Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 5+ year

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF any, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO Paralysis agitans — 10 yrs

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-25 ..., 1954, to 9-1 ..., 1954, that I last saw the deceased alive on 9-1- , 1954, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Taneytown, Md. DATE SIGNED 9/1/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 9-4-54 | NAME OF CEMETERY OR CREMATORY [illegible] | LOCATION (City, town, or county) Carroll Co. (State) Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 3, 1954 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR [signature] ADDRESS [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08354

08341 CERTIFICATE OF DEATH Reg. Dist. No. 14

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 4yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Field State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Leonardtown
STREET ADDRESS (If rural give location) Rt 5

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Magdelen (Last) Stone

4. DATE OF DEATH: (Month) Sept (Day) 6 (Year) 1954

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 2/28/94
9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): St Marys
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Alfred Stone
14. MOTHER'S MAIDEN NAME: Mary M Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk
(If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: Unk
17. INFORMANT & ADDRESS: Elsie A Stone

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 2 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Epilepsy — 46 yrs
DUE TO
(c) Uterine Carcinoma

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 23, 1951 to Sept 6, 1954, that I last saw the deceased alive on Sept 6, 1954 and that death occurred at 1:30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
H H Martin Md Sykesville Md Sept 6-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-8-54
NAME OF CEMETERY OR CREMATORY St Aloysius
LOCATION (City, town, or county) Leonardtown (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept 6, 1954
REGISTRAR'S SIGNATURE C. Harry Edwards
24. FUNERAL DIRECTOR Jos. C. Mattingley
ADDRESS Leonardtown Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

SEP
BUREAU U. S.

MARYLAND 08342 08355

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 17yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hos.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) Sykesville

3. NAME OF DECEASED (Type or Print) (First) Flora (Middle) (Last) Stubbins

4. DATE OF DEATH (Month) Sept. (Day) 5 (Year) 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH May 24, 1887

9. AGE Last birthday 67 yrs. If under 1 year Months. Days. If under 24 hrs Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Amos Fink

14. MOTHER'S MAIDEN NAME Sallie Shelter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No. -

16. SOCIAL SECURITY NO. -

17. INFORMANT AND ADDRESS Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

160X

Immediate cause (a) Cerebro-vascular accidant — Interval Between Onset and Death: 11 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis — years

(c) Diabetes — few mo

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Manic Depressive psychosis — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/19 ..., 1954, to 9/5/ ..., 1954, that I last saw the deceased alive on 9/5 ..., 1954, and that death occurred at 11:15p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gertrude Sonnenfeldt M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED 9-7-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 9-8-54 NAME OF CEMETERY OR CREMATORY [illegible] LOCATION (City, town, or county) [illegible] (State)

DATE REC'D BY LOCAL REG. Sept. 6, 1954 REGISTRAR'S SIGNATURE C. Barry Ward

24. FUNERAL DIRECTOR H. C. [illegible] ADDRESS 1020 S. [illegible] St. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08356

08343 **CERTIFICATE OF DEATH** Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Ivy (Middle) I (Last) Stull

4. DATE OF DEATH: (Month) (Day) (Year) September 30, 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: March 17, 1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Americus Wiles

14. MOTHER'S MAIDEN NAME: Sarah Hummer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. Naomi Dodrer, Taneytown, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Ventricular Fibrilation	minutes
ANTECEDENT CAUSE (S)	DUE TO (B) Myocardial Infarction	7 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Hardening of Arteries	10 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 April, 1952, to 30 Sept 1954, that I last saw the deceased alive on 30 Sept., 1954, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE Walter E. Stevenson ADDRESS Taneytown, Md. DATE SIGNED 1 Oct 54.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial DATE THEREOF 10/3/54 NAME OF CEMETERY OR CREMATORY Haugh's Mt. Zion Cemetery LOCATION (City, town, or county) (State) Ladiesburg, Maryland

DATE REC'D BY LOCAL REGISTRAR Oct. 2, 1954 REGISTRAR'S SIGNATURE Ethel M Mehring Local 24. FUNERAL DIRECTOR C.O. Fuss & Son ADDRESS Taneytown, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

08344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08357

Reg. Dist. No. 81

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keysville; LENGTH OF STAY (in this place) 6 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keysville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GRACE	EIGENBRODE	Warren	Sept.	18	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	widow	9/10/1885	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	at home	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Eigenbrode	Elizabeth Ohler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	Mrs. L. E. Hooker, Keysville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Chronic Myocarditis and Myocardial Degeneration	2 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c) Generalized Arteriosclerosis	4 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis - Cause Undetermined	1½ yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 4, 1953, to Sept. 18, 1954, that I last saw the deceased alive on Sept. 17, 1954, and that death occurred at 8:15 A.m. E.S.T., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. I. McVaugh	M.D.	Taneytown, Md.	9/18/54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/20/54	Keysville Cemetery	Keysville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19, 1954	Lucie A. Repp	D. D. Hartlove & Sons	Union Bridge, Md.

RECEIVED
SEP 21 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08358

08345 CERTIFICATE OF DEATH Reg. Dist. No. 77

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) R (Last) WILLIAMS

4. DATE OF DEATH: (Month) Sept (Day) 26 (Year) 19 54

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Feb 21 1887

9. AGE Last birthday: 67 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Williams

14. MOTHER'S MAIDEN NAME: Emma Hare

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Mrs James Williams, Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — Interval Between Onset And Death: 7 mos

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio Sclerotic C-V Disease — 7 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Sept. 26, 1954, that I last saw the deceased alive on Sept. 26, 1954, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

SIGNATURE M.C. Porterfield (Degree or title) M.D ADDRESS Hampstead MD DATE SIGNED 9-27-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept 29/54 NAME OF CEMETERY OR CREMATORY Lower Run LOCATION (City, town, or county) Bullocks (State) Md

DATE REC'D BY LOCAL REGISTRAR 9/27/54 REGISTRAR'S SIGNATURE Henry J Lewis

24. FUNERAL DIRECTOR Edw Clipton ADDRESS Hampstead Md

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 29 1954
BUREAU V. S.